

**PRIVACY RELEASE FORM**

\_\_\_\_\_  
Date

**PLEASE RETURN THIS FORM TO:**

Senator Mitch McConnell  
601 West Broadway  
Room 630  
Louisville, Kentucky 40202

**TO WHOM IT MAY CONCERN:**

I am aware that the Privacy act of 1974 prohibits the release of information in my file without my approval.

I authorize the

\_\_\_\_\_  
(name of agency or department)  
to provide information on my claim/case to Senator McConnell or his staff representative designated by him.

This authorization is good until such time as a final decision is made on my case and there is no further administrative appeal available to me.

\_\_\_\_\_  
Name - Please Print

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State & Zipcode

\_\_\_\_\_  
Day Phone Number

\_\_\_\_\_  
Evening Phone Number

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

If you wish information to be provided to parent, child, attorney or other interested party, please indicate below.

I authorize \_\_\_\_\_ to receive information from Senator McConnell or his staff representative designated by him relative to my claim/case.